



VERMONT


Department of Mental Health
Agency of Human Services
Child, Adolescent & Family Unit (CAFU)

**Home and Community Based
Enhanced Family Treatment
(EFT) Overview**



Agenda


- Description of waiver/EFT
- How EFT differs from FFS & ISBs
- Initial & Continued Eligibility Criteria
- Application & review process and timelines
- Review of forms
- IPCs & Budgets
- Self-Audits
- Q&A time for regions



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Waiver/EFT: what is it??

- Home and Community-Based 1915(c) Children's Mental Health Waiver (since 1982)
 - provides home and community-based services to individuals below the age of 22 who have a mental illness and are at risk of institutionalization. For the purposes of eligibility DMH/CAFU considers institutionalization to mean a JCAHO accredited inpatient psychiatric facility for children.
- Global Commitment (2005)
- Enhanced Family Treatment (current)
- EFT/Waivers in the world of IFS



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Why a waiver vs. FFS vs. ISB?



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Fee-for-Service

- This is how DA bills for most eligible mental health covered services under the State Medicaid Plan
- Each DA has a cap on the total amount of FFS allowed in your children's mental health budget
- Each service type has its own rate
- Each service must be documented & billed every time it's provided



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Individual Service Budget (ISB)

- DCF can purchase FFS from a DA
- Child in State's custody
- Doesn't tap into DA's FFS Cap (this is a way to expand resources to serve kids in your region – Develop a partnership with your DCF District Office!)
- Typically used for youth in an out-of-home wrap
- Allows DCF to purchase respite, crisis supports
- Simplified documentation to DMH doesn't require clinical review
- Services are billed as provided
- Must be approved by DCF Central Office

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Why an EFT/ Waiver?

- EFT allows flexibility to provide an intensive wrap of services that fluctuates day-to-day
- Don't have to document & bill each service separately
- One Daily rate billed for all services
- Does not tap into FFS Cap
- Can bill for some services that aren't covered by traditional Medicaid FFS (see allowed and excluded services lists in EFT Manual)
 - Specialized evaluations
 - Consultation
 - Therapeutic Foster Care
 - Respite
- All DA Mental Health Medicaid Services MUST be on the waiver, only exception is SB6 (school-based MH)

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CMS Home & Community Based Services (HCBS) Settings

- No longer defined by "what they are not"; are now defined by the nature and quality of individuals' experiences
- HCBS Settings must*:
 - Be integrated in, and support, full access to the greater community;
 - Be selected by the individual from among setting options;
 - Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
 - Optimize autonomy and independence in making life choices; and
 - Facilitate choice regarding services and who provides them.

*these should be developmentally appropriate in application for each individual

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HCBS Settings, cont.

- Provider-owned or controlled residence:
 - Setting is physically accessible to the individual
- Setting includes provisions that the Individual*:
 - has a lease or other legally enforceable agreement providing similar protections;
 - has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
 - controls his/her own schedule including access to food at any time;
 - can have visitors at any time
- DMH allows community-based residential settings for up to four (4) individuals for settings that meet these characteristics.

*these should be developmentally appropriate in application for each individual

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What is a “matched” waiver?

- The Child Adolescent and Family Unit (CAFU) of DMH is responsible for programmatic and financial review of the Enhanced Family Treatment (waiver)
- DCF can purchase EFT services by providing the State match (State provides \$0.40 to obtain Federal \$0.60 for every Dollar – this is old thinking, but conveys gist without detailing Global Commitment Waiver)
- DCF-Matched waiver is used for children who are in State’s custody
- DCF-Matched waivers still necessitate full DMH review of EFT criteria and are overseen by DMH
- DCF District Office must review/approve locally before submitted to DMH
- DCF Central Office must review/approve once DMH has approved

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EFT Process

1. Local determination of eligibility & necessity for EFT
2. DA’s communicate in advance with DMH Children’s Mental Health Care Manager to discuss eligibility, proposed plan, and when waiver is being considered and developed.
3. Complete Initial application packet
4. DA internal review using checklist
5. Upload to Global Scape, notify Jessica
6. DMH Technical Review
7. DMH Clinical Review & Approval/Denial
8. Signed documentation back to DA
9. Begin services and billing under EFT/Waiver
10. DA structure to review actual vs budgeted service provision



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Clinical Eligibility Criteria

- The goal of the EFT services is to maintain children **in their home and/or community or return children to their home and/or community.**
- All **alternative resources must have been explored** and determined to be inappropriate or unavailable before an application of EFT services is submitted for consideration.
- Services included under the EFT may be provided only to persons who meet **ALL** the following criteria:

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Clinical Eligibility Criteria (cont.)

1. Are a Medicaid-eligible recipient, or eligible for being “deemed” for Medicaid.
2. The services prescribed in the Individualized Plan of Care (IPC) cannot be provided by any other means

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Clinical Eligibility Criteria (cont.)

3. Are children and youth who have not yet reached the age of 22 years and are still enrolled in school:

- Alternative schools, technical schools, tutoring, a GED program, and transition age students enrolled in college classes or job training can all be considered as “enrolled in school.”
- One special note: for transition age youth who have obtained their high school diploma or GED, the treatment plan should address what services or activities the youth is involved in that are helping him/her move towards independence.

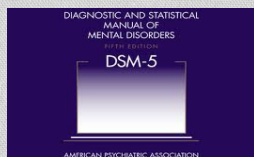


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Clinical Eligibility Criteria (cont.)

4. Have a primary diagnosis of mental illness

- A primary diagnosis of Autism or Conduct Disorder is an exclusionary diagnosis.
- Except in the case of a waiver needed to complete an evaluation, we would question the clinical intensity of a child that only had an adjustment disorder or ADHD.



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Clinical Eligibility Criteria (cont.)

5. Are currently receiving the level of care provided in an inpatient psychiatric facility, or are likely to receive the level of care provided in an inpatient psychiatric facility if intensive services are not provided.

- The Brattleboro Retreat Hospital is Vermont's only psychiatric hospital for children, but DMH may also consider placement in a Crisis Bed or Hospital-Diversion Bed.
- A step-down from residential treatment may also be considered.
- All of the above placements must have occurred within the past six months.
- In rare situations, DMH will consider other documentation of the "risk of institutional care." Examples could include a child with multiple or frequent crisis screenings, where placement was only avoided by substantial efforts from local teams.

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EFT Application Process



- EFT paperwork is due 30-days prior to the start of services for Initial and Continuation requests.
- By nature of the children served through this funding mechanism, there are times when a package of services is pulled together in response to a crisis situation and thus may not have 30-day advanced notice.
- Exceptions to this timeframe are typically granted when the DA staff person communicates the situation with their DMH Children's Mental Health Care Manager
- EFT budget periods are from January 1 – June 30 and from July 1 – December 31.

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DMH Review Process

What happens once paperwork is submitted to DMH?
(Why does it take so long?)

- Technical review by Program Tech (Jessica Whitaker)
- Communication between DMH & DA regarding missing or clarifying elements
- Once all i's dotted & t's crossed, then Children's Mental Health Care Manager will review
- Follow up from the Children's Mental Health Care Manager to discuss questions regarding adequate demonstration of clinical eligibility, plan of services, etc.

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DMH Review Process

- Decisions on initial EFT applications will be made within 14 calendar days of receipt of completed official referral.
- CAFU will notify the provider of recommended necessary changes and return the paperwork to the DA/SSA for revisions.
- A decision and/or payment for services will not begin until the paperwork is completed and a final decision is made by DMH staff.
- If the information requested to complete a referral is not provided and the referral remains incomplete by 30 days from receipt of application, the parent/guardian and DA/SSA will be notified that a determination to approve or deny cannot be made. The application will not be processed and will be returned to the DA.

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Continued Eligibility

- For an EFT renewal, the cover letter should detail:
 - what progress the child & family have made;
 - how the services continue to prevent further placements;
 - what progress is being made to transition the child out of EFT services; and
 - whether the IPC is changing and why.

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DETERMINING CONTINUED ELIGIBILITY

- Continued eligibility reviews occur on 6 month cycles for budget periods of July 1 – December 31 and January 1 – June 30.
- Thirty (30) days prior to the end date of the initial eligibility period, the DA/SSA must apply for continued eligibility.
- If the required continuing eligibility information is not submitted within 14 days of the expiration of the prior authorization or intent to apply for continued eligibility is not communicated by the DA/SSA notice of service denial will be sent to the parent/guardian and the DA/SSA.

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DETERMINING CONTINUED ELIGIBILITY cont..

- Continuing eligibility information must include one of the following options:
 - A. If the treatment plan and budget are **remaining exactly the same**:
 - A cover letter stating the treatment plan and budget are not changing and should remain the same,
 - the signature page (with required signatures outlined above),
 - a new CBCL and
 - any new evaluations completed that would support the treatment plan remaining the same
 - B. If the treatment plan and budget are **changing**:
 - A cover letter stating the changes and why, description of continued eligibility,
 - a new IPC,
 - a new budget,
 - a new signature page (with required signatures outlined above),
 - any new evaluations that support the change, and
 - a new CBCL.(See Appendix C for continued eligibility checklist).

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Grievance And Appeals

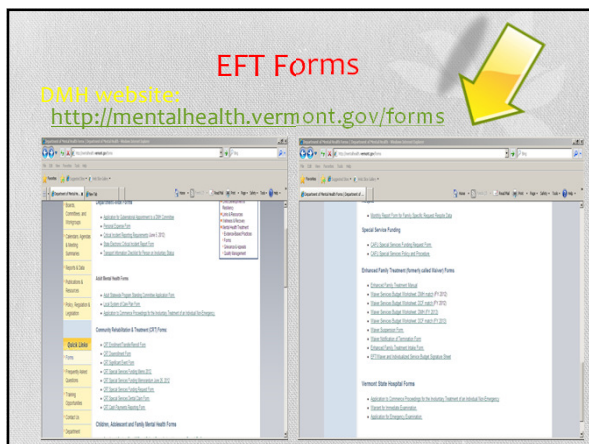
- If a child is determined to be eligible for the EFT, the child and guardian will be notified of the approved plan by the providing DA/SSA.
- If the child is determined to be ineligible for the EFT, DMH will notify the child and their guardian in writing and explain how and where to file an appeal. The DA will be copied on the written ineligibility determination. The DA will identify what other Medicaid covered services the child/family is eligible to receive.
- If a child or guardian chooses to appeal the eligibility decision, the processes outlined in the **Grievance and Appeals Procedures Under Vermont's Global Commitment to Health** will be followed.
- The full document of the **Grievance and Appeals Procedures Under Vermont's Global Commitment to Health** can be found at:

<http://mentalhealth.vermont.gov/sites/dmh/files/About/2010GAManualaddendum082312.pdf>

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EFT Forms

DMH website:
<http://mentalhealth.vermont.gov/forms>



Assessments



- A formal assessment done **within 6 months of the EFT start date**. Possible examples include:
 - Psychological or Psychiatric assessment, or
 - Discharge summary from a hospital or hospital diversion program, or
 - Discharge summary from a residential setting, or
 - Psychological components of an IEP evaluation
- It should contain the clinical information justifying EFT criteria.
 - The client's current needs and functioning;
 - Client's skills, resources, and strengths;
 - Level of supports currently available to and needed by the client to function successfully in particular community living, social or work settings.
- Supporting documents can be used to supplement the primary assessment (less than two (2) years old).

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CBCL

- The DA/SSA must provide a current (less than 60 days) Child Behavior Checklist (CBCL)
- Indicates significant mental health needs. A syndrome scale or the total score must be in order to meet criteria.
- Submit the **blue form (or copy)** **not** the scored results
- DMH enters data into ADM for aggregate analysis

Intake form

CHILD AND ADOLESCENT EFT SERVICES INTAKE

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Individual Plan of Care (IPC)

- Clinically Relevant goals/objectives
- Adhere to Medicaid quality elements (refer to Medicaid FFS Manual – see Resource list)
- Best Practice (we encourage/don't require)
 - Include all services on IPC, e.g. SB6 & Pvt Insurance, and identify as such (waiver, SB6, Pvt Ins) – use “other funding source” column on EFT budget
 - TFC on IPC if EMR allows, otherwise address in cover letter
- Range of frequency must be within reason (see EFT manual p. 15) and put average frequency on budget
- If your EMR has check-box for frequency to identify Weekly vs. Monthly – check one!

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IPC con't

- Services & Frequency must match the budget
- Handwritten changes must be initialed
- Private providers –
 - If a non-DA clinician is providing clinical services concurrent to EFT services, it must be clearly documented that the services are not duplicative to what is included in the EFT/waiver.
 - The IPC can identify that the specific clinical services is provided by a non-DA provider and should indicate coordination of care.
- Consultation: by whom & why?
- E&M (Med Management) (15 min) and Individual Psychotherapy with Medication Management (30, 45, 60 min)



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Budget

- Must match IPC (date range, svc type, frequency)
- Use current FY Rate Sheet
- Can include non-waiver services by using “Other Funding Source” column on budget
- Special Service Funding vs. EFT (e.g. for Consultations/Evals)
- Documents should be uploaded to Globalscape (faxes accepted not preferred)
- Program Tech, Jessica, can make adjustments to budget, but not to IPC

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Budget con't

Above/below the line:

what does this mean?

- **“Above the line”** = Medicaid eligible service



- **"Below the line"** = non-Medicaid items such as room & board, personal expenses



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Sample budget

[illegible]

"The Line"

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Budget Revisions – changes as of 7/1/14

- Clinical review of medical necessity and comparison of actual to budgeted service intervention should occur on a regular basis
- Budget adjustments should be made by the last business day of the 5th month in the 6-month budget period (July-Dec; Jan-June)
- Budgets may be adjusted back to the beginning of the 6-month period if necessary.
- If a **new** EFT begins in the 5th or 6th month, revisions to that initial EFT budget may be made up to 45-days past the end of the 6-month budget period (Dec 31st or June 30th).
- Documentation required: Cover letter, budget, signature page, and IPC (if svcs added/removed)

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Billing

- You are responsible for
 - ensuring continued Medicaid enrollment;
 - ensuring staff bill under the EFT code;
 - suspensions & terminations.
- Billing a “day of service” includes the day a child/ youth begins the EFT, but not the day they leave the EFT.
- The billing DA is responsible for reporting all MIS info.



Responsibility

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Self-Audits

- As of October 2013 Self Audits are now mandatory for each client's EFT funding
- Each waiver will be subject to a self-audit by the DA proving the services once per fiscal year. Within 90 days of completion of the waiver period,
- If the self-audit determines that the cost of *actual services* provided by the DA is **within** the allowable error rate of ten percent (10%) of the child's individual EFT budget, no reconciliation is required
- If the self-audit determines that the cost of *actual services* provided by the DA is **in excess** of the allowable error rate of ten percent (10%) of the child's individual EFT budget, the DA must refund the full amount of the error.
- If at the end of the original 90 day period, the DA has not completed its self-audit and submitted a report to DMH, the DMH may suspend all Medicaid EFT payments
- DMH may perform an audit on any budget at any time it is determined necessary to verify results of the self-audit and effectiveness of the DA's self-audit process.
- Please read the Self-Audit section of the manual for a more detailed explanation of the process.

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Respite and DOL/FLSA Rule Changes

- Your agency is responsible to abide by all of the Dept of Labor's Fair Labor Standards Act and the rule changes in effect January 1, 2015.
 - Minimum wage, overtime, travel costs
- EFT Hourly Respite rate ranges already above minimum wage
- DA responsible to manage potential overtime and travel costs
- Overnight Respite – Clarifications
 - Child/youth living in own home (not in custody)
- Therapeutic Foster Care – Clarifications
 - TFC is exempt from these rules
 - Any child/youth in TFC (in custody or not)
 - Primary TFC home and Secondary TFC home. Both homes must be licensed.
 - Child/youth in custody, placed back in own home may have foster home as secondary home.

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EFT Overnight Respite Rates

- EFT Overnight Respite rate ranges adjusted to minimum wage
- Assumes 16 hours work in 24-hour period, with 8 hours sleep
- Be aware of DOL rule: **if child needs attention during sleep period, provider must be paid for that time**
- VT minimum wage is \$9.15
- O/N Respite rate range now uses hourly rates: **\$9.15 – \$10.00**
- To calculate Overnight Respite:
 - Determine #hrs per overnight.
 - Select hourly rate from Overnight Respite rate range.
 - Calculate cost of Overnight Respite = $\#hrs \times \$hrly \text{ rate}$.
 - Bottom of Range: $\$9.15 \times 16 \text{ hrs} = \146.40
 - Top of Range: $\$10.00 \times 24 \text{ hrs} = \240

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Setting the Rate for Therapeutic Foster Care

The state allows a **range of rates** for TFC. Setting the rate with a prospective foster placement should take into account at least (but not limited to) the following criteria:



- ❖ The child's need for supervision and general risk level
- ❖ The skill level or specific expertise necessary to meet the child and/or family's needs
- ❖ The other services provided to the child that impact the time the TFC provider spends with the child

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TFC Rates Continued

In special cases, DMH may approve an increase of the TFC rate of up to 20% if the child exhibits **significant** high risk behaviors. For example:

- fire-setting
- sexual offending
- self-harming
- aggressive behaviors



The DA must receive **prior approval** of this increased rate from their DMH Care Manager before submitting a waiver application.

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Termination & Suspension Forms

- Max of 21 days are allowed for suspension
- Suspended temporarily: hospitalization, Hospital Diversion program, away community, or from EFT services.
- Termination notification to DMH within 15 days of termination of services; includes reasons for termination.
 - A day of service does not include the day the child leaves the program.

• Forms located on DMH website

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Medicaid Deeming



Medicaid deeming is a process where DMH can “deem” a child eligible for Medicaid due to their extraordinarily high need for medical coverage of specialized services.

- The child must be clinically eligible for EFT services
- This type of Medicaid can ONLY be used for home and community-based services
- While Medicaid deeming does **NOT** take into account the parents’ income or resources, the child by him/herself must meet the income and resources guidelines for Medicaid
- Deeming only lasts for the length of the EFT services, so the family should immediately be supported in applying for “Katie Beckett” Medicaid. This allows Medicaid funding to continue past the waiver, or covers additional services in situations where the child escalates further and needs a higher level of care

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EFT and Private Providers:

- If there is a private clinician providing treatment to the client, it can now be billed directly to Medicaid, as long as it does not duplicate a service that is included on a waiver.
- If a treatment team would like this private provider (who is now billing Medicaid directly) to participate in the treatment team meetings, they may, if appropriate, pay that provider for consultation. However, the consultation must then be included on the waiver budget.
- DA/SSA providers cannot bill separately for any clinical Medicaid services provided to an EFT recipient. All DA/SSA mental health Medicaid services must be on the EFT, with the exception of Success Beyond Six Services.
- For children on a Medicaid Waiver, Success Beyond Six Medicaid (or any school based mental health service), may be billed for school supports if:
 - The mental health services are provided in the school environment.
 - Goals and services must be identified in the Individual Plan of Care.



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EFT and “Pass-Throughs”

- When EFT services are being provided by more than one DA, we call it a “Pass – Through.”
- When considering a Pass-Through Waiver, teams should discuss who will be the clinical “lead” in directing the treatment, who will be providing the majority of the services, and which agency the child will discharge to. These questions should be used to determine who will be the “lead” DA on the waiver.
- The responsibility for submitting the EFT packet then falls with this lead DA.
- Services can (and often should) be provided by both DA’s. If so, the budget will simply list two lines for each provided service (i.e. two service coordination lines, etc.).
- However, if two DA’s are providing the same service, it is both their responsibilities to ensure there is no duplication in the service being provided, or double-billing for attendance at the same meetings.
- We prefer that there be one combined IPC, but will accept two if necessary.
- The “serving” DA will bill the lead DA for services provided, and the “lead” DA submits the overall bill to HP for reimbursement.
- The DA or any contractor providing the services on the waiver is responsible to provide documentation of treatment services to the lead DA to include in the child’s medical record.

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Change in Custody Status While Receiving EFT Funding

If a child/youth is receiving EFT services and their custodial status changes, the following steps will be taken to determine if and when fiscal responsibility transfers. The following process should be used to determine the date that funding of EFT services changes:

For children in DMH funded placements who enter DCF custody:

- When a child who is receiving EFT Services enters DCF custody, DCF assumes fiscal responsibility on the date the child enters custody.
- Once notified that a child has entered DCF custody, the DA staff must follow the steps outlined in the manual for “Documenting of Fiscal Changes.”

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Custody Status Change cont’d

For children in DCF funded placements who have a planned discharge from DCF custody:

- If the discharge from custody is planned, the local team (including at least local DCF, MH, and education), should begin planning for the transition at least **3 months** prior to the custodial transfer.
- If the child will remain in a paid out-of-home placement, then there must also be State DMH approval of the placement, so local teams may need to allow time for that process.
- If DMH approves the placement prior to discharge from custody, then DMH becomes the immediate payee when custody changes.

For children in DCF funded placements who have an unplanned discharge from custody:

- If there is an unplanned discharge from DCF custody while a child/youth is using EFT services and the team wishes to continue with the current plan, DCF and DMH must communicate immediately about the status of the case and need for placement.
- If DMH approves the placement, then fiscal responsibility will transfer from DCF to DMH on the date of discharge from custody.
- Without DMH approval of the funding, the plan is not guaranteed and placement may end.

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Suggestions:

- Have a point person to streamline communication with DMH
- If you have different people writing the application than managing/overseeing EFT services, ensure solid communication
- Communicate with your (DA) business office
- Conduct internal technical & clinical review before submitting EFT packets to DMH
- Keep copies of documentation that you submit
- Upload applications to Globalscape. Faxes are accepted, but not preferred. If you upload or fax, don't also mail.
- We are all responsible to uphold HIPAA in our communications, especially via email
- Don't hesitate to call if unsure or have questions!!



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In Summary



- Communication with DMH early, before submission of application
- Communication during technical & clinical review
- Goal for all is to process quickly and allow service & billing to begin
- Delays impact DA budget & DMH budget
 - 6-month Medicaid billing window

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Resources

- EFT Manual and Forms:
- <http://mentalhealth.vermont.gov/forms>
- Medicaid FFS Regulations/Info:
<http://mentalhealth.vermont.gov/sites/dmh/files/publications>
- Medicaid Fee-For-Service Procedures Manual (2014)
- Medicaid Reference Manual (January 2005)



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